Family Planning and Health Systems Unit

Facilitators Module
Group Counseling for Promoting Modern Family Planning

Deliverable No. 5

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Facilitators Module
Group Counseling for Promoting Modern Family Planning

Background and Rationale

In the LEAD for Health's effort to reduce fertility through increasing CPR, family planning services will be made more widely available. Efforts will also focus on increasing the acceptance of highly reliable methods that are less familiar to couples, and reducing drop out rates for oral contraceptives and DMPA injectable contraceptives.

One of the period benchmarks that relates to these aims is:

- □ Training modules on FP Group Counseling techniques drafted.

Experiences with group counseling to increase acceptance of voluntary surgical sterilization (VSS) and to increase new acceptors of combined oral contraceptives (COCs) make this approach promising.

Period Progress

In February, Dr. Douglas Huber from MSH/Boston and JPHIEGO staff Dr. Ricky Lu and Dr. Ron Magarick supported the LEAD for Health team in developing approaches for the Project's family planning strategy, including initial consideration of training issues and service approaches. "Procedural" methods (IUDs and VSS) were of key focus but other FP counseling and service provision issues were also reviewed.

With the LEAD for Health FPHS Unit, this team met with DOH regional teams in Regions VI and XII and some provincial health personnel. They visited health centers and RHUs to meet with Municipal Health Officers and family planning service providers in Tanza (Cavite); Bacolod, Bago City (Negros Occidental); Talisay (Cebu); and Pantukan and Lupon (Davao Oriental). They also visited district hospitals in Urdaneta and Valladolid in Pangasinan and the Davao Regional Medical Center.

While the key focus of these visits was on 'procedural methods', some facilitators of "group counseling" were provided with opportunity to reflect on the experience while others, to provide inputs into how such an approach might be useful and workable in their setting.

Findings and Conclusions

This area was not the primary focus this period, given the intensity of the other FP strategy activities. However, in the facilities the team visited where group counseling had been active, discussion around the activity and provider point of view will feed into developing a curriculum from the initial guide developed by Save the Children which was adopted by the project (Please see attached).

Providers find the holding of these several-hour long sessions with couples and individuals to be gratifying and useful. Although time consuming, they reach more couples at one time and are much more effective in increasing a thorough understanding of how methods work and the effects they might have. Techniques used in the sessions are effective in opening up conversation and are therefore effective in eliciting concerns about methods from the participants.

Although to date the nurses have been conducting the sessions, it is expected that the midwives and BHWs will be the most appropriate personnel to be engaged in such a community-based activity. Materials to train these new categories of personnel will need to be tailored accordingly.

There is a sense that the sessions are long, but that the time is needed for what they intend to accomplish. It may be necessary to adapt these sessions to being held on weekends and other times that are more convenient for the target couples and individuals.

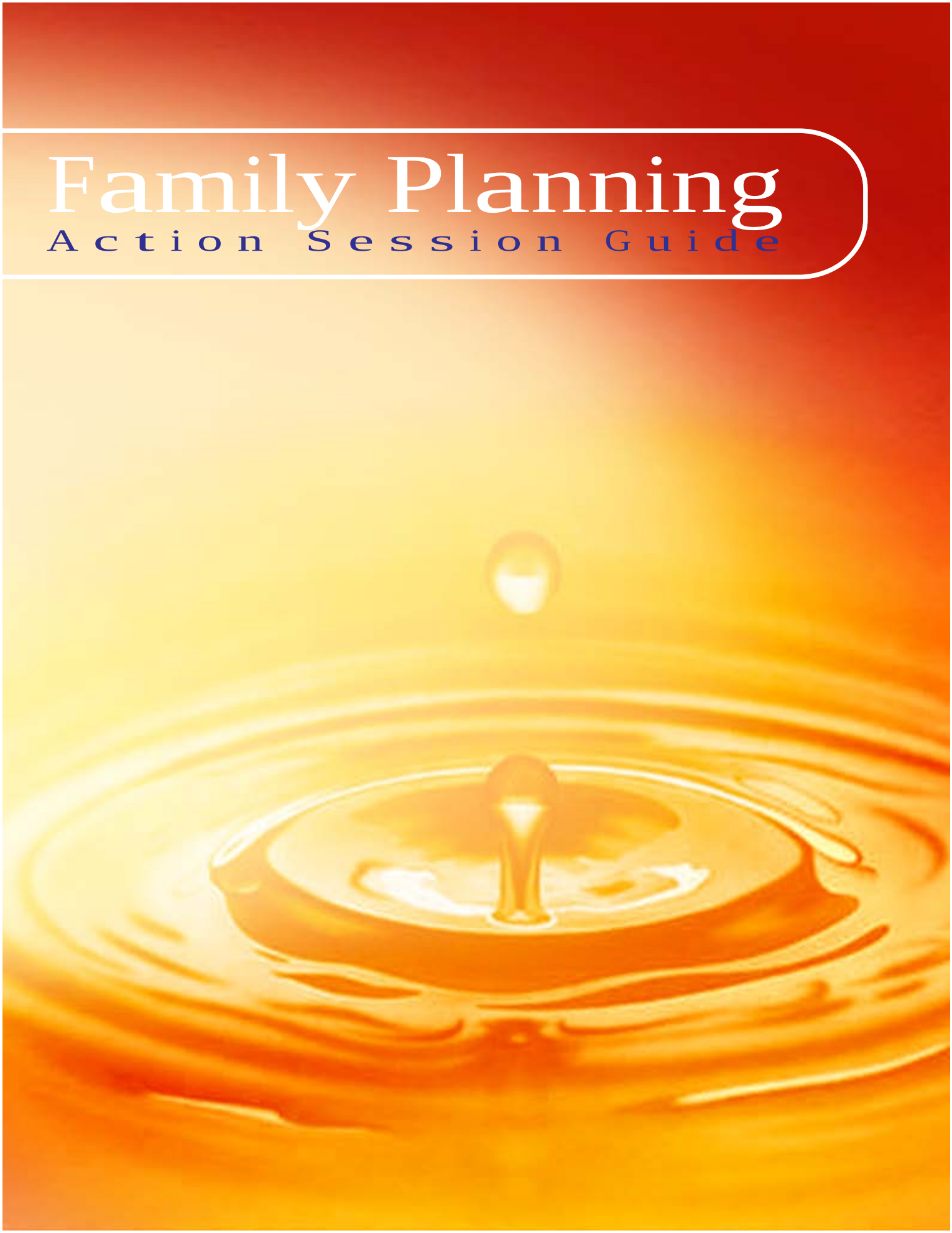
The attached guide will be adopted by the project for use by professional health staff. A similar guide will be developed for non-professionals such as BHWs.

ANNEX

Facilitators Module:
Group Counseling for Promoting Modern Family Planning

Family Planning

Action Session Guide



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Notes to the Facilitator

Facilitators Module
Group Counseling for Promoting Modern Family Planning

This module was developed to help facilitators conduct group counselling sessions for promoting modern family planning among couples of reproductive age. The counseling sessions are designed to increase appreciation of family planning, and encourage greater utilization of family planning services at health centers,

The module consists of two parts: a Family Planning Action Session Guide, and a Family Planning Session Reference.

The Session Guide contains step-by-step instructions for facilitating group sessions on family planning. There are seven sessions:

Introduction
Task 1: Anatomy of Human Reproduction
Task 2: Couples' Perceptions of Family Planning and Risk Groups
Task 3: Family Planning Methods
Task 4: Testimony of Successful Couple
Task 5: Family Planning Action Card
Task 6: Next Steps and Evaluation

For each of these sessions, the guide provides the Session Title, Session Objective, Time Allocation, Equipment/ Materials Needed, and Procedure.

The Family Planning Session Reference is a complement to the Session Guide. The Reference contains notes and technical content; illustrations are also included for better appreciation of specific topics. The reference is meant to be the main resource of the facilitator in conducting the group sessions. It is the Session Guide's important partner.

This facilitators module was developed jointly by Save the Children/ US and Management Sciences for Health, with a grant from the USAID.

Notes to the Facilitator

Some Reminders:

1. Review the Session Guide to familiarize yourself with its content, activities and requirements.

2. In your mind, go over what you will do to give you a feel of the process of the session before you actually conduct it.

3. Study the corresponding reference notes to help you better elaborate on the topics.

4. Practice with your co-facilitator, if you have one, before the actual session.

5. Ensure that the workshop venue has adequate space for all session activities.

6. Make sure that all supplies, equipment, materials, and visual aids are complete and readily available in the workshop room.

7. Identify the couple who will make the testimony based on the criteria set forth in the Family Planning Reference. Make sure to brief both partners in advance; give them guide questions to help them prepare a focused testimony.

Introduction

Expected Participants:
10-15 Couples of Reproductive Age (15-49 years old) with unmet needs for family planning

I. INTRODUCTION

Start the session with a short prayer followed by an ice breaker. An action song may be introduced.

A. Introduction of the participants and facilitators

Objective: The Participants/couples shall be able to know each other better and discover something in common with other participants/couples

1. Introduce yourselves first to encourage the couples to introduce themselves and make them comfortable with you as facilitators.

2. Ask each couple to introduce themselves by sharing the following about themselves:

   a) Names including nicknames

   b) Number of children and spaces (number of months or years) between children

   c) Experiences in family planning, including methods used or being used (for those who have had the experience)

   d) Challenges as parents and/or as spouse

3. Acknowledge the group for being open and for sharing their lives to the group.

Ask the participants about the insights that they have gained from sharing personal information.

Another facilitator may write responses on the board or manila paper so that the participants will appreciate the purpose of the activity.

B. Expectation Check

Objective: To enable the participants as well as the facilitators to identify, discuss and agree on the different expectations of the session.

1. Divide the group into three by counting 1 to 3 around the group.

2. Give each group manila paper with assigned questions to be answered. The participants will write their answers on the manila paper. The questions to be answered are:

Materials for the whole session

Visual Aid: Objective of the Family Planning Session, Schedule of the Session, Visual Aid per Task, Human Anatomy (Male & Female),Family planning status of Couples in the Sitio, Standard meaning of family planning, Reasons for Family Planning, Family planning methods, Male & Female Reproductive System, Human Activities on Environment, Action Card, Consolidation of couple's intentions, Consolidation of Couple's actions and needed support

Standard Materials: Sticker for IDs, Manila Papers, pentel pens, ballpens, stickers or plastic dolls, masking tape, action cards, brochures and pamphlets

Materials

Manila Paper &
Pentel pen

a. What do you expect to learn after this session?

b. What do you expect from the facilitators?

c. What do you expect from your co-participants?

3. Give each group 3 minutes to answer the assigned questions.

4. A reporter of each group will present their answers and the other participants will give their comments, discuss and agree on the answers.

5. Post each group's output on the wall. On the manila paper containing the expectations of the participants of their co-participants, facilitators and participants make their signatures to signify that they agree to respect these. This sheet then serves as the group's learning contract during the session.

6. Use theses expectations as a springboard for discussion of the session on objectives.

II. PRESENTATION OF GENERAL OBJECTIVES and TASKS

Objectives:

1. Identify the different terms that are appropriate & comfortable for all the participants to use in referring to vagina, penis & sexual intercourse.

2. Identify & discuss the different parts of function of the male & female reproductive organ.

3. Discuss the meaning of Family Planning & the different reasons why there is a need to practice Family Planning.

4. Discuss the different Family Planning methods like its description, side effects & the myths & misconceptions.

5. Identify the positive effects of Family Planning in the lives of a couple using an Family Planning method.

6. Identify their Family Planning intentions & the activities & needed support to achieve their plans.

Materials

Visual Aid: General Objectives and Tasks

Task I: ANATOMY OF HUMAN REPRODUCTION

A. WORD GAME

Objective: To enable the participants to be more comfortable in saying the terms used in referring to vagina, penis, and sexual intercourse. This would help the facilitator to determine the specific words to be used that the participants feel comfortable using.

Allotted Time: 20 mins.

1. Divide the participants into three groups.

2. Post the three sheets of manila paper with label each: A) VAGINA; B) PENIS; and C) SEXUAL INTERCOURSE.

3. Let the small group stand in front of each posted manila paper and write down in 30 seconds as many terms as they know that are used to refer to the word listed on the corresponding sheet. The terms could be those that they use or terms they have heard others use.

4. Let the groups exchange sheets upon your signal, and continue listing the words that have not been identified yet.

5. After all the terms have been written down, post all the sheets in front. Ask all the participants to read the words aloud together in a certain way as instructed (i.e., angry, crying, laughing, singing, whispering)

6. Then ask the following questions:

   a) What have you done as a group?

   b) How do you feel while reading/writing down these terms? Why?

   c) Why were you asked to write and recite these words?

   d) What can you note from the terms used to substitute for the real words used? Which words refer to males, to females only?

   e) What are the terms that you are comfortable using, and why?

   f) What are the terms that you are not comfortable using, and Why?

   g) What lessons have we learned from this particular activity? How can we apply them in our lives?

Materials

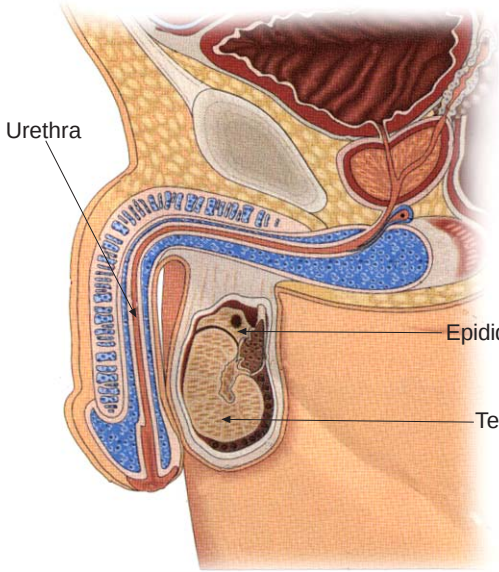
manila paper with labels of penis, vagina, and sexual intercourse.

B. FUN WITH ANATOMY

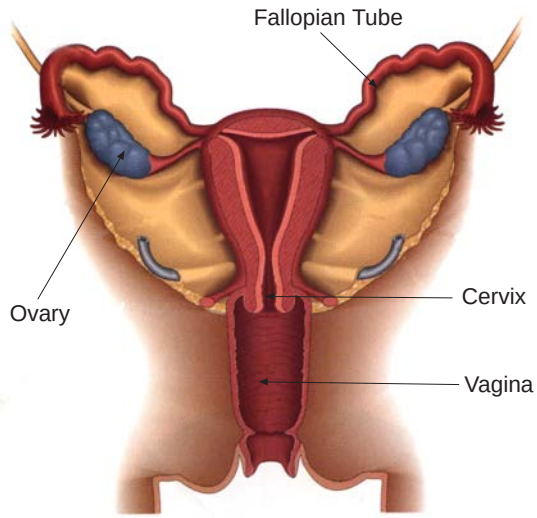
Objective: The participants/couples shall be able to identify and discuss the different parts of the male and female internal and external reproductive organs and discuss their respective functions.

Allotted Time: 45 mins.

Male Human Anatomy



Female Human Anatomy



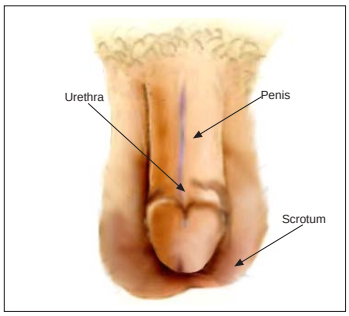
Materials

Visual aid – male and female anatomy, clay, outline picture of male and female anatomy, **used folders**, glue

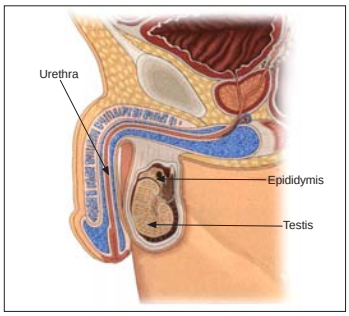
Task I

1. Divide the participants into five groups.

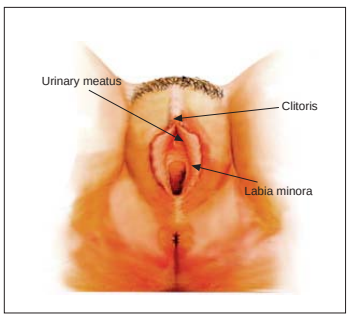
a) Male external reproductive organs



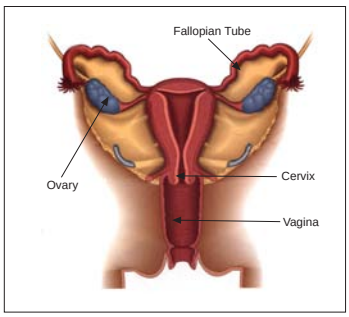
b) Male internal reproductive organs



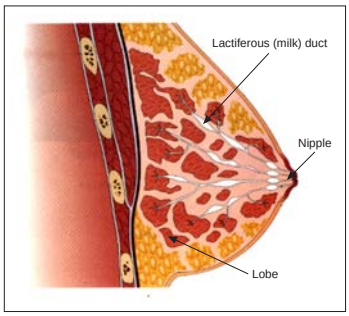
c) Female external reproductive organs



d) Female internal reproductive organs



e) Breast



2. Distribute illustrations of the specific organ assigned to each group. One group is asked to work on the breast, another on female external reproductive organs, another group on male external reproductive organs, the fourth group on female internal reproductive organs, and the last, on male internal reproductive organs. Also distribute used folders, molding clay and pentel pens.

3. Let the participants either draw or mold the parts of their assigned organ using clay. They may stick the clay on the drawing and label the parts within 10 minutes.

4.Then let the participants discuss in their respective small groups thefunctions of the different parts in 5 minutes.

5. Each group presents and discusses its output.

6. Acknowledge the group's output and clarify, correct misconceptions/information and explain the part and functions in details using the visual aid (male and female anatomy).

Note: Encourage the participants to ask questions or share any information relevant to the discussion.

7. When all the parts were presented and discussed, ask the participants the following:

a) What did we do?

b) How did you feel when you were discussing among yourselves the parts assigned to your group? Why?

c) How did you feel when the parts were presented and discussed in the whole group? Why?

d) Why do you think we did this particular activity?

e) What lessons have you learned from this activity? How will you apply them in your lives?

Task II: COUPLES' PERCEPTION OF FAMILY PLANNING AND THE DIFFERENT RISK GROUPS

Objective: The participants/couples shall be able to discuss the meaning of Family Planning and the different reasons why they need to practice family planning.

Allotted Time: 45 mins.

Materials

Visual aid – Standard meaning of Family Planning, Reasons for Family Planning, manila paper, pentel pens

A. MEANING OF FAMILY PLANNING

1. Ask the participants the following questions:

a. How do they understand family planning?

b. Whose responsibility is family planning? The wife? The husband? Or both? Why?

Note: Emphasize that family planning is a couple's decision. Please refer to the notes for the discussion.

4. Write down all answers; group similar or related answers to perceived meaning of family planning. Compare it with the standard definition (refer to reference notes)

B. RISK GROUPS

1. Ask: What are the reasons or situations when a couple needs to practice planning?

You may classify the reasons given based on the following:

a) Too young (woman is below 18 years old)

b) Too old (woman is 35 years old and above)

c) Too many (couple has more than 3 children)

d) Too soon (spacing between children is less than 2 years)

e) Too sick (woman has serious illness)

2. Consolidate answers of the participants. Discuss the reasons that they mentioned. You may use the pictures as indicated. Refer to reference notes for the discussion guide.

After soliciting ideas from the participants, you show the right answer as below,

Example: Too many children (more than 3 children)

a. Too young (woman is below 18 years old)

1) How many of us here had a child before reaching 18 years old?

2) What happens if a woman gets pregnant when she is too young, less than 18 years old?

b. Too old (woman is 35 years and above)

1) Ideally, at what age should a woman stop bearing children?

2) What happens if a woman gets pregnant when she is more than 35 years old?

c. Too many (couple has more than 4 children)

1) Ideally, why do you think a mother would limit the number of children?

2) What do you think will happen to her health if she gets pregnant more than three times?

d. Too soon (spacing between children is less than 2 years)

1) How many years do you consider as appropriate spacing between children?

2) What happens if **a** mother gets pregnant too soon or less than 2 years of spacing between children?

e. Too sick (woman has serious illness)

1) What diseases do you consider serious such that pregnancy or childbirth may result to the eventual death of the mother **and/or** the baby?

2) What happens to the fetus and the mother herself if she has a serious disease?

3. Summarize Task II by posting the 7-column canvass of couples with unmet needs in front.

   a) Ask each couple to stick the figure of a cut-out doll, given to them earlier, in the column which they think would apply to them. (Remind the participants that these cut-out dolls, represent themselves.)

   b) When all the couples have posted their cut-out dolls, ask these questions:

   - Which column has the least number of couples? Why do you think?
   - Which column has the most number of couples? Why do you think?
   - How did you feel when you were posting your cut-out dolls? Why?
   - Why have we learned from this exercise?
   - How will we apply them in our own setting/ situation?

4. Relate this activity to the next task.

Kahimtangan sang pagpaminata sang mag asawa sa sitio

Sitio _____

Petsa _____

					
Pregnant	*Tama ka bata* (Manubo sa 18 anyos ang nanay)	*May edad na* (Masobra sa 35 anyos pataas ang nanay)	*Tama ka damu* (Masobra sa 3 ka bilog ang kabataan)	*Tama ka ikit* (Kulang sa 3 ka tuig ang lang at pagpamata)	*May malala nga masakit* (Sakit sa korason, TB, cancer)

Task III: FAMILY PLANNING METHODS

Objective: The participants or couples shall be able to discuss the different family planning methods and clarify any misconceptions they have or have heard

Allotted Time: 45 mins.

1. Ask: What family planning methods do you know?

2. Write their responses on the board.

3. After soliciting responses from the participants, show to them the various family planning methods.

Materials

Visual aid – manila paper labeled with different method

Task III

4. Divide the group into 11 small groups. Each group is meant to discuss one of the following family planning program methods:

   a. Lactation Amenorrhea Method

   b. Mucus/ Billings Method

   c. Basal Body Temperature

   d. SymptoThermal Method

   e. Standard Days Method

   f. Pills

   g. Depo-Medroxy Progeterone Acetate (DMPA)

   h. Condom

   i. Intra Uterine Device (IUD)

   j. Ligation

   k. Vasectomy

5. Assign each small group a specific method. Instruct them to write one description, action, advantages or myths that they know of the method.

6. Through a carousel method let the group write their responses on the manila paper and pass it to the next group until all methods are completed.

7. Post all the responses in front for all the participants to see.

8. Discuss the description, action and advantages of each method as well as clarify the myths and misconceptions about these methods as explained in the attached notes.

Introduce the next activity. For example, mention that some couples have actually used family planning methods successfully. We have invited one of them to share their experience with us.

Task IV: TESTIMONY OF THE SUCCESSFULL COUPLE ON FAMILY PLANNING

Objective: Participants shall be able to learn from the successful couple the positive effects of family planning in their lives and family.

Allotted Time: 30 mins.

Task IV

A. AS A PREPARATION TO THIS TASK

1. Choose a successful couple using the following criteria:
   - practicing a program modern family planning method
   - spacing between children is 3 years or more
   - with 2-3 children who are healthy
2. Give the couple a copy of the following guide to prepare them on their testimonials:
   - How many children did you plan to have?
   - What made you decide on the number of children?
   - What challenges did you encounter in pursuing your plan? How did you overcome them?
   - Who supported you?
   - What made you sustain your plan?

B. SESSION PROPER

1. Introduce the successful couple to the participants.
2. Let the successful couple tell their experiences to the group based on the guide you gave in 5 minutes.
3. Then, thank the couple and ask the group:
   - What did you feel while listening to the successful couple's story?
   - What interest you in their story?
   - What questions would you like to ask the couple? Give them time to make and ask questions.
   - What message or lesson do you get from the sharing? How will you apply them in your life?

Task V: FAMILY PLANNING ACTION CARD

Objective: For the participants/couples to write their decision on the Family Planning Action Card.

Allotted Time: 45 mins.

1. Post a larger version of the action card in front.

2. Distribute the action cards to the couples.

3. Discuss the content of the action card using the following as guide:

   a. They should choose only one of items 1-4 that applies to them.

   b. All participants should have a response to questions 5 and 6.

4. Tell the participants to be careful in prioritizing what they want to undertake and their needed support.

5. Give 5-10 minutes for the couples to discuss and to decide, and complete the action card.

6. Make sure that the participants have answered the action card completely and they have filled up two copies.

7. Leave one copy of the action card to the couples and gather the other copy from them.

Note: To guide them, the 7 column canvass should still be posted. Give more assistance to couples who have difficulty reading the guide or those who have difficulty filling up the card.

Materials

Family Planning Action Card canvass, Family Planning Action Card form, ballpens

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FAMILY PLANNING ACTION CARD

Please check the family planning status that applies to you:

☐ **1. We do not want to have any more children but are currently using a family planing method. We are using a family planning method. We are using the_____(cite method)**
Please check the reason for family Planning use:
- ☐ **We already have the desired number of children**
- ☐ **Wife is too sickly**
- ☐ **Wife is too young or too old**
- ☐ **Cannot afford to have any more children**
- ☐ **Others: _____**

☐ **2. We do not want to have any more children using Family Planning method:**
Please check the reason for not using Family Planning method:
- ☐ **Had difficult experiences during childbirth**
- ☐ **Because of the side effects**
- ☐ **Because it is against our religion**
- ☐ **Wife or husband will not permit or decide whether to use a method**
- ☐ **Others: _____**

☐ **3. We cannot decide whether to have any more children or not but are currently using a family planning method. We are using the _____ (cite method)**
Please check the reason for Family Planning use:
- ☐ **We already have the desired number of children**
- ☐ **Wife is too sickly**
- ☐ **Wife is too young or too old**
- ☐ **Cannot afford to have any more children**
- ☐ **Others: _____**

☐ **4. We cannot decide whether to have any more children or not but are not using a family planning method**
Please check the reason for not using Family Planning method:
- ☐ **Had difficult experiences during childbirth**
- ☐ **Because of the side effects**
- ☐ **Because it is against our religion**
- ☐ **Wife or husband will not permit or decide whether to use a method**
- ☐ **Others: _____**

5. In the next month, we are going to do the following activities to achieve our plans

When	What	Where

6. What are the support needed to achieve our plans?
_____
_____

Mr. _____ Age: _____ Occupation: _____
Mrs. _____ Age: _____ Occupaton:
_____Number of Children: _____ Age of youngest child: _____
Religion: _____ Barangay: _____

Task VI: NEXT STEPS AND EVALUATION

Consolidation of couple's action and support needed:

What	When	Where	Support Needed

Materials

Consolidation of Couple's action and support needed

A. Consolidation of couple's action and support needed:

1. Consolidate the responses made by the participants in questions 5 and 6 in the action card. Post the list in front.
2. Ask the participants if they would like to have another session as a group as an immediate next step. If they say yes, agree on the date and venue.
3. Emphasize the schedule when couples could visit the health center for Family Planning counseling.

B. Evaluation

1. Ask: the participants the following questions:
   a. Which part of the session you like most?
   b. Which part of the session you like least?
   c. Which part of the session you found most significant as a couple? Why?
   d. Which part of the session you found difficult? Why?
   e. Would you like to attend a follow up session on family planning?
2. In closing, allow the participants to make a concrete commitment to their plans. Ask them to sign or make a hand print on the space around the consolidated couples' action plans.
3. Thank the participants/couples. Remind them again of the services and schedule of the Health Center.

Family Planning

Session Reference

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Family Planning Session Reference

The Family Planning Session Reference is a complementary of the Family Planning Action Session Guide. This contains notes and technical content of the Session Guide to help the facilitator in discussing a particular task/activity. Specifically, this material discusses the details of Task I, B (Fun with Anatomy); Task II Couple's Perception of Family Planning and the Different Risk Groups); and, Task IV (Family Planning Methods). Illustrations are also included for better appreciation of the specific topics.

Please take special care not to separate this material from the Session Guide as this is its important partner.

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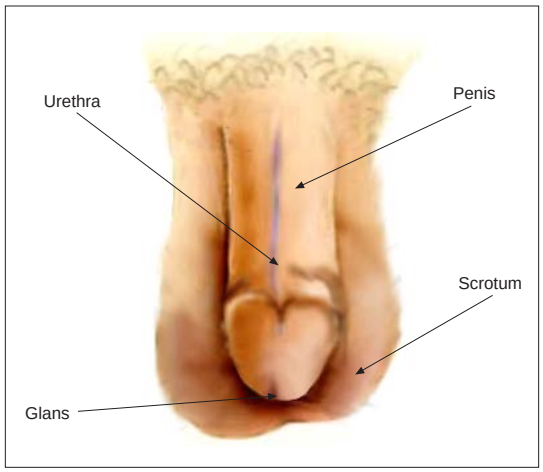
ANATOMY OF HUMAN REPRODUCTIVE (Task 1)

A. Word Game

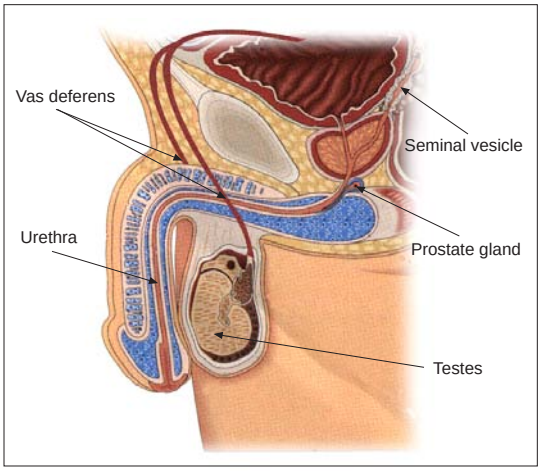
B. Fun with Anatomy

1. Parts and Functions of the Male External Reproductive Organ



a. Penis – the main vehicle that transports semen to the vagina for reproductive purposes.
b. Scrotum – a pair of sac that hangs under the penis. It is covered by wrinkled skin that serves to maintain the testicular temperature. It houses the testes.
c. Glans – the head of the penis.

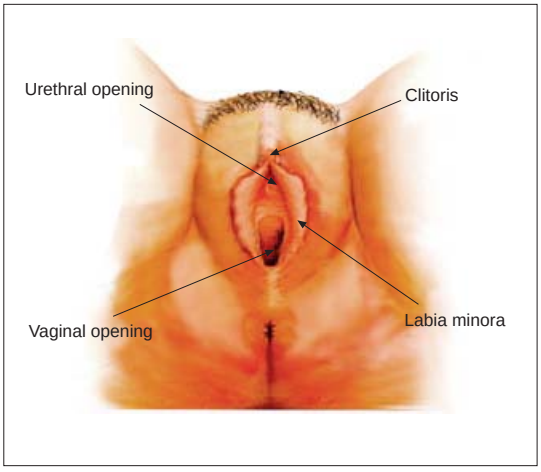
2. Parts and Functions of the Male Internal Reproductive Organ



a. Vas deferens – a pair of tubes that serve as passageway of the sperm from the testes to the urethra.
b. Seminal vesicle – an organ that produces semen. It contains mucus that gives sperm cell energy.

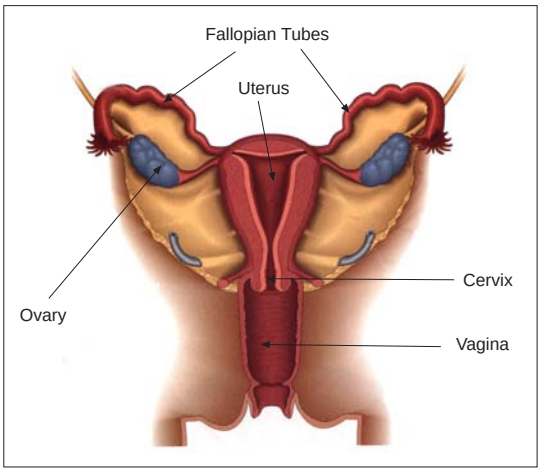
c. Prostate glands – a small cone-shape organ that emits fluid that makes the sperms coming from the testes to remain alive.
d. Urethra – serves as a channel for all male sexual fluid. It is also the conduit from the bladder to the opening in the penis.
e. Testes – produce and store sperm. They also produce a hormone accountable for male sexual urges.

3. Parts and Functions of the Female External Reproductive Organ



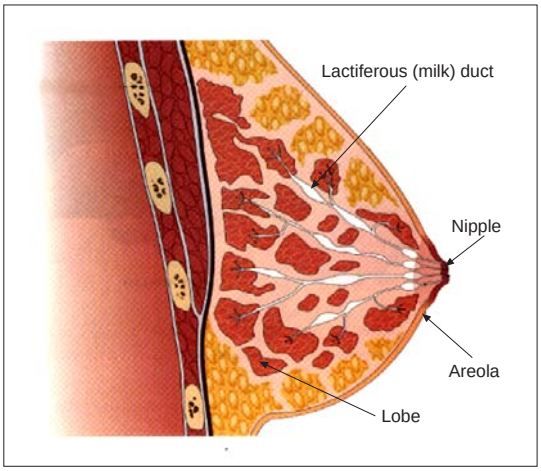
a. Vagina – a tubular sex organ where menstrual discharges pass out of the body. It stretches to function as a birth canal. It is the place where sexual intercourse occurs. It is also the channel through which the sperm travel up toward the fallopian tube to fertilize an egg.
b. Labia majora – outer covering of the vagina.
c. Labia minora – inner covering of the vagina
d. Clitoris – the most sensitive part of the female reproductive organ. It is equivalent to the penis of the males.
e. Urethral opening – the passageway of the urine.

4. Parts and Functions of the Female Internal Reproductive Organ



a. Ovaries – a pair of bean-shaped organ where the egg cell is developed and released every month. This is equivalent to the male testes. They also manufacture female hormone that is responsible for menstrual cycle.
b. Uterus – the place where the fertilized egg develops and grows into a fetus. It houses the fetus until it is mature enough to be delivered. The uterus is also the origin of the bloody discharge that usually occurs monthly during the reproductive years of the woman.
c. Fallopian tubes – the place where sperm and egg meets and fertilization takes place. These are the passageways of the egg cell from the ovary to the uterus, if fertilization does not occur.
d. Cervix – a small opening at the top end of the vagina leading to the uterus. During pregnancy, it is sealed off to stop infection and allow amniotic fluid to fill the uterus. When the fetus is mature and ready to come out, the cervix dilates wide enough to form a passageway of the fetus from the uterus to the vagina.

5. Parts and Functions of the Female Breast



a. Areola – a circular, pigmented area in the center of the breast.
b. Nipple – a rounded protruding structure that lies in the center of the areola. This is where the baby sucks milk from the mother during breastfeeding. It is also a point for sexual stimulation.
c. Milk glands – produce and store milk during pregnancy.
d. Milk ducts – serves as the passageway of the milk.

IMPORTANT POINTS TO REMEMBER

Four Prerequisites for Pregnancy to Occur:

1. healthy sperm of the man

2. ovum of the woman

3. meeting of sperm and ovum resulting to fertilization in the normal place inside the reproductive organ of the woman

4. healthy place in the uterus for implantation of the fertilized ovum

The above points are the same pre-requisites that can be interfered with the artificial methods of spacing or limiting pregnancies:

1. No-Scalper Vasectomy and condom – result in no sperm for fertilization

2. Pills, DMPA and other hormonal methods – result in suppression of ovulation (production of ovum)

3. Condom and IUD – prevent ascent of sperm to the uterus thus prevent the meeting of the sperm and egg cells.

4. Tubal Ligation – closing of the fallopian tubes thus preventing the meeting of egg with sperm.

MSH MANAGEMENT SCIENCES FOR HEALTH

Save the Children
Philippines Field Office

COUPLE'S PERCEPTION OF FAMILY PLANNING AND THE DIFFERENT RISK GROUPS (TASK II)

A. Meaning of Family Planning

Family Planning refers to having children based on the couple's belief, health and economic situation. It also refers to birth spacing, having the number of children the couple can responsibly raise and giving birth of the mother at the right time or age.

Family planning is a couple's responsibility.

Couples should be involved in making decisions related to family planning, including how many children, when to have children, whether or not to practice family planning and which method to use.

B. Risk Groups.

The following are the health reasons why the couples need to practice family planning:

1. Too young (mother is less than 18 years old)

Women below 18 years old have much higher risk of developing complications during pregnancy and/or childbirth.

The body of a woman below 18 years old is not yet ready for the rigors of pregnancy and childbirth. Her womb is still developing fat deposits that will serve as a cushion for the growing fetus. Her pelvic muscles

and bones are also still developing. Pregnancy will interfere with the normal growth and development of her reproductive system. Parenthood is a demanding responsibility, thus the woman needs to be emotionally, mentally, socially, physically and financially prepared for it.

Health risks of pregnancy below 18 years of age:

a. Bleeding or hemorrhaging during pregnancy – her womb is not yet strong enough to hold the growing fetus.

b. Iron deficiency Anemia - the woman needs the nutrients for her growing body and sharing those with her baby would deplete the needed nutrients and will put her and the baby into danger.

c. **Prolonged and more difficult (and painful) labor** - her body is still developing into maturity and is not yet ready for the rigors of labor.

d. **Toxemia or blood poisoning -** this may be due to a problem with the placenta. The woman may have spasms of the vessels, which increase her blood pressure. The blood flow to the placenta may impair it, which if uncontrolled can damage the placenta and cause the death of the fetus.

f. Miscarriage - her pelvic muscles are not yet strong enough to hold the growing baby in place. Growth of the pelvic muscles is completed seven (7) years after onset of menstruation. Pregnancy interrupts the process.

g. Premature birth - her cervix maybe weak that easily opens from the pressure put on her uterus as pregnancy advances. This may also be due to malnutrition or stress.

h. Death at birth (Stillbirth) - this may be due to a problem with the placenta that severely interfered with the flow of blood, oxygen and nutrient for the fetus.

i. Less likely to gain weight during pregnancy -leading to low birth weight baby which is associated with infant and childhood disorders and high rate of infant mortality.

j. High incidence of ectopic pregnancy (growth of the fetus inside the fallopian tube) – this maybe because the body of the woman is still developing and is not yet ready for pregnancy.

2. Too old (mother is above 35 years old)

Generally, older mothers have more difficult pregnancies and deliveries and take longer time to recover following childbirth. There is an increased incidence of cardiovascular diseases.

Health risks of pregnancy 35 years old and above:

a. **Miscarriage** - the rate of miscarriage rises with material age. The uterus may have become lax or can no longer expand to accommodate the growing fetus.
b. **Chromosomal abnormalities in the baby** - this is associated with hormonal changes among older women which can lead to Down's Syndrome (a birth defect characterized by mental retardation, slow growth, broad hands and feet, small head, flat nose, slanting eyes and a tendency towards developing serious heart defects).
c. **Low birth weight babies** - after the age of 35, the uterus may no longer expand sufficiently to accommodate the growing fetus. Thus, babies born to these mothers may have low birth weights.
d. **Death at birth (Stillbirth)** - women who become pregnant in their late 30's will most likely have stillborn babies.
e. **Toxemia or blood poisoning (eclampsia/pre-eclampsia)** - this may be due to the increased incidence of hypertension and cardiovascular problems among older mothers. Generally,older mothers are stressed by the biological demands of pregnancies.
f. **Medical complications** - women in this age group are at high risk of developing complications from chronic hypertension.

3. Too many (more than 4 children)

Women who have four (4) or more children have an increased risk of dying from further pregnancies. A woman's health and nutritional status deteriorate after too many and closely spaced pregnancies. The effects of having too many children do no stop at pregnancy and childbirth. Taking care of the growing children may take a heavy physical, mental, emotional and financial toll on the woman and her family.

Health Risks of mothers associated with too many children especially with advancing age.

A. **Miscarriage** - the muscles of the pelvic organs become lax due to repeated pregnancies and cannot hold the growing fetus to its full term.
b. **Hemorrhage** - this maybe due to a weak contraction of the uterus or a problem with the placenta or stress after too many pregnancies.
c. **Iron deficiency Anemia** - pregnancy depletes the nutritional health of the mother. Too many pregnancies (especially if these are closely spaced) would put stress on her health.
d. **Rupture of the uterus** - associated with repeated pregnancies.
e. **Premature birth** - her cervix maybe weak that easily opens from the pressure put on her uterus as pregnancy advances. This may also be due to malnutrition or stress.
f. **Death at Birth (Stillbirth)** - this is an adverse effect of repeated and closely spaced pregnancies.
g. **Low birth weight baby** - a depleted health of a mother would result to a low birth weight baby that is associated with infant disorders.

4. Too soon (spacing between children is less than 2 years)

Women who become pregnant at an interval of 24 months or 2 years or less are putting themselves and their children in danger. They are physically strained and drained by pregnancy. They need 2 to 3 years to regain their health and proper nutrition status.

Having children less than 3 years interval would mean that a woman maybe taking care of 3 or 4 children below 5 years old at the same time. This would put a heavy physical, emotional and financial toll on the woman and her family. Children will have smaller share in family resources and parental time and care.

The chances of survival of the youngest born child are low. With too many young children to take care of, the mother may not be able to give quality care to all especially the youngest that needs more attention. She also would not have enough time to take care of herself.

Health Risks associated with too close birth interval

a. **Iron deficiency Anemia and malnutrition** – with repeated and closely spaced pregnancies, the mother would not be able to recover her lost blood and nutrients fully. Pregnancy puts a heavy toll on her health as well as the health of her baby.
b. **More vulnerable to illnesses** – this is due to the failure of the mother to regain her health fully after delivery. For a healthy mother to bear healthy children, she needs enough time to recover the lost blood and nutrients during her previous pregnancy.
c. **Low birth weight babies** - this may lead to lower resistance to communicable diseases and slow growth.
d. **Shorter duration of breastfeeding** – this has adverse effect on the health of the baby and the mother would have early return of fertility.

5. Too sick (with existing illness)

Women who are malnourished, anemic, has diabetes or other diseases has great risks of getting pregnant. The illness of the woman affects the normal process of the pregnancy and at the same time, the pregnancy can aggravate the existing disease conditions. Medications can have bad effects on pregnancy. Pregnancy can further aggravate the illness.

For example, a woman who has a serious disease such as heart failure, cancer, tuberculosis, etc, may die due to the physical demands of pregnancy.

Health risks of the following diseases to the mother and/or baby:

- **Tuberculosis:**
  1) Illness can cause low birth weight to the fetus or even stillbirth;
  2) The baby is at high risk of also getting the diseases;
  3) If the mother gets pregnant, she has to stop taking the medicines because of the bad effects of the drugs to the pregnancy.

- **Heart disease:**
  1) During pregnancy, heart failure can occur anytime due to the stress of pregnancy on the heart;
  2) After childbirth, failure may occur due to overloading of the circulation of the blood from the placenta after the retraction of the uterus.
  3) High incidence of complications:
     - Abortion
     - Very slow growth of the baby inside the uterus which may result to low birth weight
     - Stillbirth or death at birth
     - Premature labor

- **Cancer:**
  1) If the mother stops her therapy due to pregnancy, her condition may only worsen;
  2) The baby may suffer from complications because of the medicines the mother is taking;
  3) There is an increase risk of stillbirth, very slow growth of the baby inside the uterus that may result to low birth weight.
  4) High incidence of miscarriage due to the medication the mother is taking.

- **Hypertension:**
  Known risks are:
  1) Pre-eclampsia or toxemia (which damages the mother's kidneys, eyes, liver, and can weaken the heart. If toxemia is untreated, it will develop into eclampsia, seizures which can be fatal to the mother and child);
  2) Premature birth;
  3) Very slow growth of the baby inside the uterus thus resulting to low birth weight;
  4) Death of the fetus;
  5) Death of the mother due to cerebral (brain) hemorrhage;
  6) Hemorrhage or Miscarriage due to the untimely detachment of the placenta;
  7) Acute renal failure.

- **Diabetes:**
  High incidence of:
  1) Birth defects of the baby;
  2) Miscarriage;
  3) The baby may grow excessively large because of the high levels of the blood sugar of the mother; and,
  4) Caesarian section because the baby is too big and caesarian section is very risky for a diabetic mother.

- **HIV/AIDS:**
  1) High risk of transmitting HIV to the baby;
  2) High incidence of a caesarian section;
  3) If the mother choose to stop taking medication during pregnancy, her HIV disease could get worse;
  4) If the mother would continue taking her medicine during pregnancy, the baby might have some birth defects;
  5) A mother with HIV cannot breastfeed her baby because HIV might be transmitted to the baby.

FAMILY PLANNING METHODS (Task IV)

A. Types of Family Planning Program Methods:

1. Lactational Amenorrhea Method (LAM)
2. Basal Body Temperature (BBT) Method
3. Ovulation Method (OM) or Cervical Mucus Method
4. Sympto-Thermal Method (STM)
5. Standard Days Method (SDM)
6. Pill
7. DMPA (Depo-Medroxy Progesterone Acetate) or Injectables
8. Condom
9. IUD (Intra-Uterine Device)
10. Bilateral Tubal Ligation (BTL)
11. Vasectomy

B. Discussion by Method

A. Lactational Amenorrhea Method (LAM). It is a temporary introductory postpartum method of family planning based on the physiological infertility experienced by breastfeeding women. LAM has been proven to be more that 98% effective if a woman meets the following three (3)criteria established for use of the method:

- the woman is amenorrheic (her menstruation has not yet returned after giving birth);
- she is fully breastfeeding her baby;
- her baby is less than six (6) months old.

When any of the above 3 criteria is no longer met, the woman has to use another family planning method.

Advantages

- LAM is available to all postpartum breastfeeding women.
  - The use of LAM does not require a physical examination.
  - No supply needed.
  - With LAM, protection from an unplanned pregnancy begins immediately after giving birth.
  - It contributes to improved maternal and child health and nutrition.

Disadvantages

- LAM is a short-term family planning method that is only effective while the woman is on full breastfeeding.
- Its effectiveness decreases once the mother is separated from the baby of extended periods because the mother is working outside the home, or for whatever reasons.
- Full breastfeeding may be difficult to sustain for up to six (6) months due to a variety of social circumstances.
- No protection from STDs or HIV/AIDS.

Possible Side Effects

There are no known side effects of LAM.

Common Myths

Myth: I cannot use LAM because I have no milk

Fact: All women who have just given birth have milk. Once a woman gets pregnant, she is also starting to produce milk. Her milk would be adequate for the needs of the baby. The mother continues to produce milk for as long as the baby continues to suckle. It is the suckling stimulation that triggers the flow of milk.

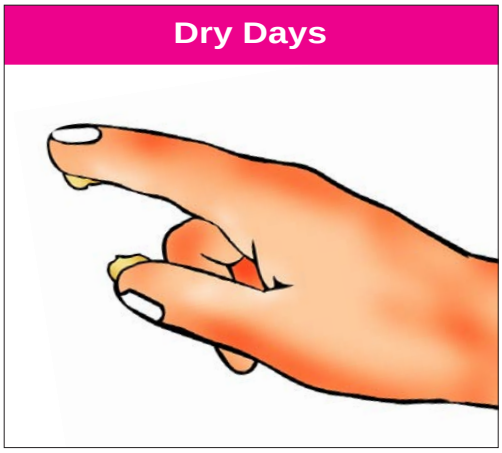
Myth: I cannot get pregnant because I am breastfeeding. I am breastfeeding and I have not had my menstruation yet.

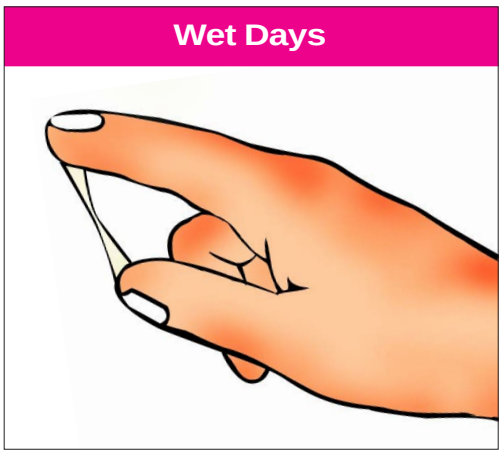
Fact: Full breastfeeding will delay the return of fertility and prevent pregnancy only in the first four to six months, after which breastfeeding women should use another form of contraception (like condoms or NFP), particularly when they start giving the baby supplementary foods.

B. The Ovulation Method (OM) or Cervical Mucus Method. The woman observes the changes of her cervical mucus based on sensation and appearance. The woman then records her observations (what she sees and what she feels) daily in a chart.

The following is a typical mucus pattern:

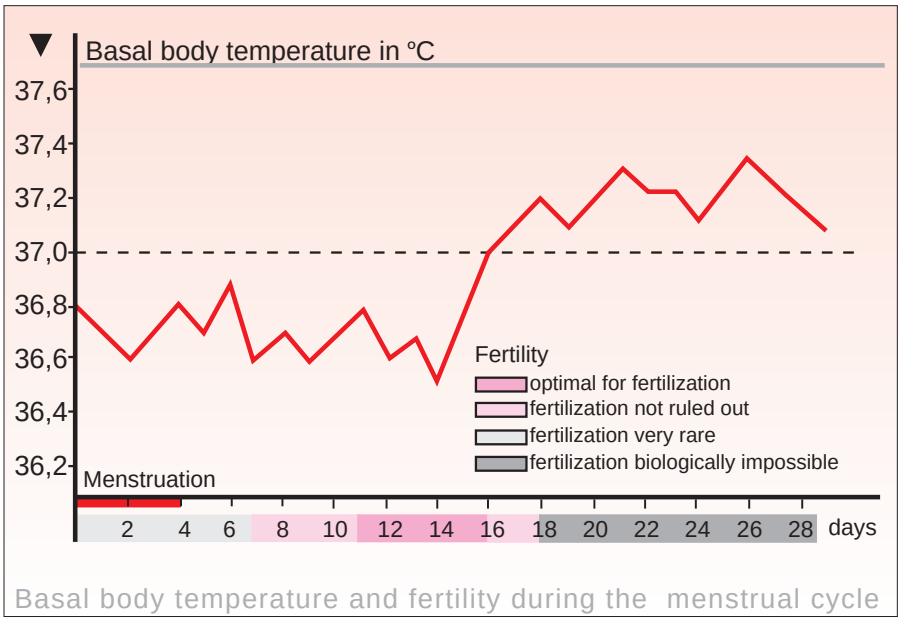
1. Dry days. This happens after end of menstruation when most women experience no mucus and later the appearance of sticky, pasty or crumbly mucus and they feel dry.





2. Wet days/ovulation period. The mucus becomes wet, gradually increases in quantity and becomes clearer in color. During the time of ovulation, it is very wet, stretchy and slippery which may look like a raw egg white. The last day of the slippery, watery mucus and wet sensation is called the peak day.
3. Infertile period begins on the fourth day after the peak day and continues until menstruation begins.

C. Basal Body Temperature (BBT). It is the temperature of the body at rest after at least three (3) hours of sleep before taking the temperature. A woman's BBT rises during her ovulation period and stays on a higher level until the next menstruation, due to a rise in progesterone level. The woman records her daily temperature reading in a chart.



Basal body temperature and fertility during the menstrual cycle

Using Basal Body Temperature Method (BBT)

1. The woman must take her body temperature in the same time each morning before she gets out bed. She must know how to read a thermometer and must record her temperature on a special graph.

2. The woman's temperature rises 0.2° to 0.5° C (0.4° to 1.0° F) around the time of ovulation (about midway through the menstrual cycle for any women).

3. The couple avoids sex, uses a barrier method, from the first day of menstrual bleeding until the woman's temperature and stayed up for 3 full days. This means that ovulation has occurred and passed.

4. After this, the couple have unprotected sex (over the next 10 to 12 days) until her next menstrual bleeding period begins.

D. Sympto-Thermal Method (STM). This method combines the observations made of the cervical mucus and temperature-recording and other signs of ovulation to determine the fertile and infertile days.

Using the Sympto-Thermal Method (STM)

1. The couple starts avoiding unprotected sex when the woman senses cervical secretions. For more protection, the couple can start avoiding sex with the first day of menstrual bleeding.

2. The couple keeps avoiding unprotected intercourse until both the fourth day after peak cervical secretions and the third full day after the rise in temperature (BBT). If one of these events happens without the other, the couple waits for the other event before having unprotected sex.

3. Other signs and symptoms of ovulation include: abdominal pain, cervical changes, and breast tenderness.

E. Standard Days Method

The Standard Days Method (SDM) is a new method of natural family planning. It identifies days 8-19 of a woman's cycle as the fertile days. The couple uses a device called the "Cycle Beads" to identify the fertile and infertile days.

The "Cycle Beads" has 32 beads composed of the following: one red bead, which represents the first day of menstruation, followed by six brown beads for infertile days, then 12 white beads for fertile days, and, 13 brown beads for infertile beads.

Note: Women with regular menstrual cycle ranging from 26 to 32 days can use the method.

How to Use the Standard Days Method:

1. Determine the client's length of menstrual cycle. It should fall within the range of 26-32 days. If the cycle length is less than 26 days or more than 32 days, she should not use the method.

2. If the client qualifies, she is provided with instruction and counseling. If possible, it is important that the clients bring her husband along.

3. The client is provided with SDM card and the "Cycle Beads" and instructed to use it in marking the days of her cycle.

4. The 'Cycle Beads" has 32 beads were colored-coded to represent, more importantly, the fertile and infertile days. A rubber ring that fits into the beads is used to mark the days in the cycle, represented by colored beads.

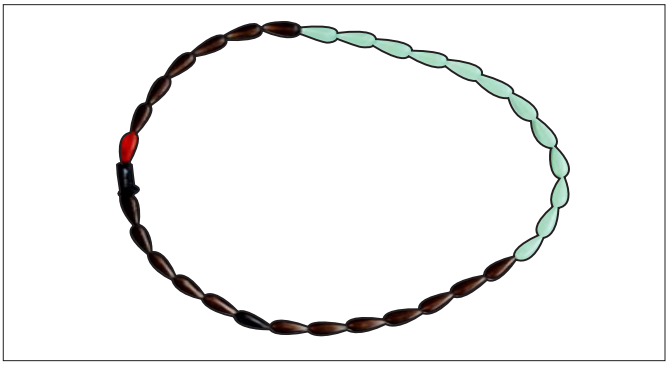
The red bead represents the first day of menstruation. It is followed by 6 brown beads that indicate the pre-ovulation infertile days, and the 12 white beads that mark the fertile days. The 13 brown beads that follow represent the post-ovulation infertile days.

5. To mark the first day of the menstruation period in the "Cycle Beads", the client simply moves the rubber marker on the red bead. She should record the date of the first day of menstruation in the SDM card. She can use this later to check if she has already moved the marker or not.

6. The client moves the rubber ring to the next bead every morning until the first day of her next menstruation. If this does not fall on the red bead, then she should move it to the red bead to mark the first day of her next menstruation.

What are the advantages of SDM?

1. Safe, easy to learn, easy to use
2. 95% effective when correctly used
3. Provides opportunity for open communication between couples
4. The necklace is low-cost and is a one-time purchase even when not provided free by the center.



What are the disadvantages of SDM?

1. Cannot be used by women with very short (less than 26 days) or long (more than 32 days) menstrual cycles.
2. Needs the cooperation of the husband for a back-up method to be very effective.

Advantages of Cervical Mucus Method, BBT, STM and SDM

- These methods can be used to either avoid or achieve pregnancy.
- There is no health-related side effects associated with their use.
- The correct use of these methods increases self-awareness and knowledge of human reproductive functions.
- Promotes involvement of the male partner, as well as cooperation and communication between partners for family planning practice.
- It is acceptable to some couples regardless of culture, religion, socio economic status and education.

Disadvantages of Cervical Mucus Method, BBT, STM and SDM

- The woman has to keep daily records of signs and symptoms of fertility.
- Require couple's motivation and ability to follow instructions.
- Require partner's cooperation
- Some couples experience emotional stress due to the need to abstain from intercourse during certain days.
- No protection from STDs/HIV
- May be difficult to detect a woman's fertile period (close to menopause, during breastfeeding, or in women with irregular cycles)

Possible Side Effects

There are no known side effects of Cervical Mucus, BBT, STM and SDM

Common Myths

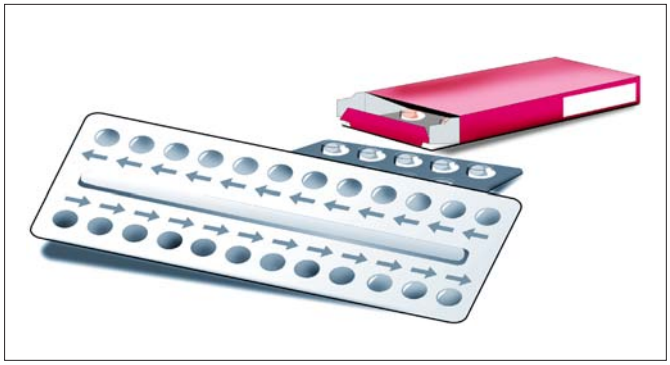
Myth: I can no longer get pregnant because I am already a grandmother.

Fact: A physically healthy woman who is ovulating and menstruating and has not yet reached menopause can still get pregnant.

Myth: A woman will get pregnant only if she has intercourse on the 14th (or any other definite day) of her menstruation cycle.

Fact: Menstrual cycle vary from one woman to another and from. One cycle to another. The time of fertility (or days when a woman can get pregnant) cannot be accurately predicted from one cycle to the next. A couple using NFP can determine whether the woman is fertile or not byobserving, recording and interpreting correctly the signs and symptoms of fertility daily.

F. Pills – a combination of hormones estrogen and progesterone that is taken daily. The pill prevents the eggs from maturing and being released from the ovary. Thus, pregnancy is prevented.



	Combined Pills	Progestin-Only Pill
How do they work?	· stop ovulation (release of eggs from ovaries). · also thicken cervical mucus, making it difficult for sperm to pass through.	· thicken cervical mucus, making it difficult for sperm to pass through · stop ovulation (release of eggs from ovaries) in about half of menstrual cycles.
How effective?	· *Effective as commonly used*- 6 to 8 pregnancies per 100 women in the first year of use (1 in every 17 to 1 in every 12). · *Very effective when used correctly and consistently*- 0.1 pregnancies per 100 women in first year of use (1 in every 1,000)	*For breastfeeding women:* Very effective as commonly used- about 1 pregnancy per 100 women in the first year of use. *For all women:* Very effective when used correctly and consistently- 0.5 pregnancies per 100 women in the first year of use.
How to use	The pill should be taken by mouth daily preferably at the same time of the day. · Initial dose should be taken at day 1 or at any day from day 1 to day 5 of the menstrual cycle;	*Same as combined pills EXCEPT:* · The pill can be started as early as 6 weeks after childbirth. · The client should always take one pill every day. If not

	then one tablet daily until the contents of the whole packet are consumed. · client using the 28-day packet should start a new packet on the next day. · those using 21-day packets should start a new packet after a seven-day rest period.	breastfeeding, it is best to take the pill at the same time each day if possible; even taking a pill more than a few hours late increases the risk of pregnancy, and missing 2 or more pills in a row greatly increases the risk. *Starting the next packet:* When the client finishes one
		packet, she should take the first pill from the next packet *on the very next day.* All pills are active, hormonal pills. There is no wait between packets.
What to do when a pill is missed	Depending on the number of pills missed, the client may have the following advices: · *One pill missed* Take one as soon as she remembers and another pill at the usual time she takes it. · *Two up to four pills missed* in *the first 14 tablets of the packet cycle.* The client should take the most recently missed pill as soon as she remembers, discard the other missed pills and should continue with the rest of the packet (including the brown tablets) at the usual time she takes the pill. She should abstain from sex or take additional precaution for seven days. · *Two up to four pills missed in the 15th -21st tablet of the packet cycle* the client should take the most recently missed pill as soon as she remembers, discard the other missed pills and continue with the rest of the packet. She should discard the brown tablets and start a new packet as well as take additional precaution for seven days. Advise the client to return to the family planning clinic for consultation. · *More than four pills missed* counsel the client that the pills may not be the method for her. Assist her to choose another method. In the meantime, advise her to abstain	If the woman forgets one or more pills: She should take 1 as soon as she remembers and then keep taking 1 pill each day as usual. · A breastfeeding woman using progestin-only pills for extra protection is still protected if she misses pills. · If more than 3 hours late taking a pill, a woman who is not breastfeeding or who is breastfeeding but her menses have returned should also used condoms or else avoid sex for 2 days. She should take the last missed pill as soon as she can. Then she should keep taking 1 each day as usual.

	from sex or a backup method until a new method is consistently in use,	
Advantages	· safe and 99% effective if used consistently and correctly · reversible, rapid fertility return · easy to discontinue use · do not interfere with intercourse · have beneficial effects (anemia, menstrual improvements, reduce risk of breast, ovarian and endometrial cancer, protection from ectopic pregnancy and symptomatic Pelvic Inflammatory Diseases (PID) requiring hospitalization, anemia, benign breast disease) · regulate menstrual cycle · reduce dysmenorrhea or pain in the abdomen associated with menstruation · decrease premenstrual symptoms · can be used by any woman of any age whether or not they have had children · can be used by women over 35 years old (even up to the age of menopause) for as long as there are no contraindications (based on recent studies)	· can be use by nursing mothers starting 6 weeks after childbirth. Quantity and quality of breast milk do not seem harmed. · no estrogen side effects. Do not increase risk of estrogen-related complication such as heart attack or stroke. · can be effective during breast feeding · even less risk of progestin-related side effects, such as acne and weight gain. · may help prevent: - benign breast disease - Endometrial and ovarian cancer - Pelvic inflammatory disease
Disadvantages	· require daily use · no protection against STDs/HIV	· less common side-effects include headaches and breast tenderness · should be taken at about the same time each day to work best. For women who are not breast-

		feeding, even taking a pill more than a few hours late increases the risk of pregnancy, and missing 2 or more pills increases the risk greatly. · do not prevent ectopic pregnancy.
Possible side-effects	· headaches · nausea · spotting · breast tenderness · mood changes · weight gain · dizziness · amenorrhea (no menstruation)	Same as the combined pills except: · amenorrhea or irregular bleeding and spotting in a breastfeeding woman *(reassure the woman that this is normal during breastfeeding, whether or not a woman is using progestin-only pills).*
Problems that requires medical attention	· Severe, constant pain in the belly, chest, or legs. · Any very bad headaches that start or become worse after she begins to take combined pills. · Brief loss of vision, seeing flashing lights or zigzag lines (with or without bad headache); brief trouble speaking or moving arm or leg. · jaundice (skin and eyes look yellow)	· Unexplained abnormal vaginal bleeding that may suggest pregnancy or an underlying medical condition. · heart disease due to blocked arteries, or stroke · very bad headache

Who should not use?
Women who have the following conditions (contraindications):

· pregnant or suspected to be pregnant

· breastfeeding during first six weeks postpartum (not a good method for women who want to continue breastfeeding beyond six months)

· undiagnosed vaginal bleeding of suspicious nature

· current breast cancer

· liver tumors, active hepatitis or severe cirrhosis

· greatly increased risk of cardio-vascular conditions:

- hypertension (blood pressure of 180/110mmHg and higher)
- diabetes
- history or current varicosities
- history of stroke

Note to facilitator: Emphasize that pills are very effective when taken every day.

Common Myths:

Myth: Pills accumulate inside the body.

Fact: Like any other medications that are taken, pills are easily broken down and absorbed in the body.

Myth: Pills can cause cancer

Fact: Pills help prevent endometrial cancer, ovarian cancer, ovarian cysts, pelvic inflammatory disease and benign breast disease. Pills also help prevent ectopic pregnancies. There are many factors that contribute to cancer: like, family history, genetic, high protein diet, life styles, etc. It is very important to consult a doctor before taking pills. It is also important for the woman-using pill to visit the doctor regularly or upon advice.

Myth: Pills can cause birth defects and abnormalities in the baby.

Fact: There is no evidence relating abnormalities or birth defects with pill use. Defects may be hereditary or lack of nutrition during pregnancy.

Myth: Pills may cause a woman to become forgetful.

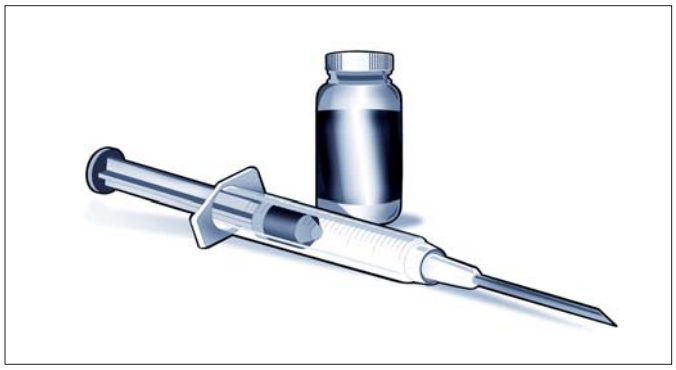
Fact: Pills act on the reproductive system specifically in the inhibition of ovulation but it has no effect on the mental processes.

G. DMPA (Depo-Medroxyprogesterone Acetate) – an injectable form of contraception that contains synthetic progesterone. It prevents ovulation and thickens the cervical mucus for 3 months. Thus, the sperm is prevented from meeting the egg. It is injected in the muscle of a woman's arm or buttocks once every three months.

What are the available brands in the Philippines?

· Depo Provera 150 mg single 1 cc or 10 cc Depo Medroxy Progesterone Acetate (DMPA)

· Megestrone 150 mg single 1 cc DMPA



Who should not use?

Women who have the following conditions (contraindications):

- pregnant or suspected to be pregnant
- undiagnosed vaginal bleeding of suspicious nature
- current or history of breast cancer
- liver tumors, active hepatitis or severe cirrhosis
- age 35 or older, who smoke heavily (20 cigarettes/day or more)
- active hepatitis or liver tumor
- greatly increased risk of cardio-vascular conditions:
  - Hypertension (blood pressure of 180/110mmHg and higher)
  - diabetes
  - history or current varicosities
  - history of stroke

Advantages

- good choice for breastfeeding mothers
- safe, highly effective and long acting, very low dose
- reversible
- easy to use (no daily routine)
- do not interfere with intercourse
- reduced risk of pelvic inflammatory infection
- may have beneficial effects similar to pills

Disadvantages

- changes in the menstrual cycle. Some women will experience unpredictable cycle or prolonged bleeding or spotting
- there is a delay in the return of fertility upon discontinuance of use
- amenorrhea in some women
- no protection against STDs/HIV

Possible side effects/Reactions

- irregular or prolonged bleeding
- spotting
- headache
- nausea
- breast tenderness
- weight gain
- mood change
- acne
- amenorrhea

Problems that requires medical attention:

- Bothersome extremely heavy bleeding (twice as long or twice as much for her).
- Very bad headaches that start or become worse after she begins DMPA.
- Skin or eyes become unusually yellow.

Common myths

Myth: DMPA causes cancer.

Fact: DMPA helps protect against uterine cancer, endometrial cancer, ovarian cancer. Cancer is caused by many factors: like, family history, genetic, high protein diet, life styles, etc. It is always advised to consult a doctor before DMPA injection.

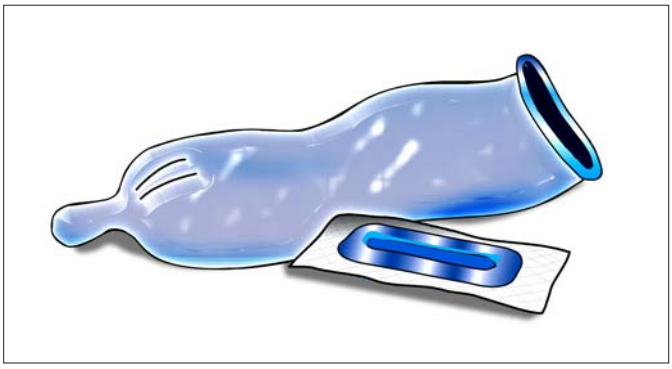
Myth: DMPA causes abnormal or deformed babies

Fact: There is no medical evidence that DMPA causes abnormal or deformed babies. There have always been incidences of abnormalities and birth defects, even before DMPA was used. Birth defects may be caused by genetic factors or inadequate nutrition and lack of prenatal check up.

Myth: DMPA accumulates in the body and causes cancer

Fact: There is no evidence that shows DMPA causes cancer. There are many factors that contribute to cancer: like, genetic, high protein diet, life styles,

and other existing factors. A woman can have DMPA for as long as she does not have any of these risk conditions. It is very important to visit the doctor before and after DMPA injection.



H. Condom – a thin rubber (latex) sheath worn on the man's erect penis before sexual intercourse, to catch and prevent the sperm from entering the vagina. It is the only method of contraception that provides protection from STDs, including HIV.

Who can use condoms?

- Men and women at risk of STDs/HIV, but there is not 100% guarantee
- Men and women of any reproductive age and parity who do not want to use other methods for personal reasons.
- Men and women who need a temporary method (back-up method) while waiting for the appropriate schedule for another method.
- Men and women who have infrequent intercourse

Putting on a Condom

1. Hold the pack at its edge and open by tearing from a ribbed edge.
2. Hold the condom so that the rolled rim is facing up, away from the penis.
3. Put the condom on the erect penis before the penis touches the vagina.
4. Pull the foreskin back if the penis is uncircumcised.
5. Place the condom on the tip of the penis.
6. Unroll the condom all the way to the base of the penis. The condom should unroll easily. If it does not, it is probably backwards. If more condoms are available, throw this one away and use a new condom. If this is the only condom available, turn it over and try again.
7. After ejaculation hold the rim of the condom to the base of the penis, so it will not slip off. The man should pull his penis out of the vagina before completely losing his erection.

8. Take off the condom without spilling semen on the vaginal opening.

9. Throw the condom away in a toilet, burn it, or bury it. Do not leave it where children will find it and play with it. Do not use a condom more than once.

Advantages

- Safe
- Easily available in most places
- Prevent both pregnancy and STDs/HIV (when used consistently and correctly)
- Easy to initiate and discontinue use
- Immediate return to fertility
- Have virtually no side effects (except rare allergy to latex)

Disadvantages

- Not as effective as other methods in typical use
- Require motivation to use consistently and correctly
- Require partner's cooperation
- Require re-supply
- May interrupt sexual activity or reduce sexual pleasure
- Require proper storage of supply and careful disposal of used condom

Note to facilitator: Condom protects against pregnancy and sexually transmitted disease (STD's), including HIV/AIDS.

Common Myths

Myth: If the condom slips off during sexual intercourse, it might get lost inside the woman's body.

Fact: The condom should be rolled down to the base of the erect penis. If the condom is put on properly, it will not slip. The condom cannot get lost inside the woman's body because the cervix, which is the entrance to the uterus cannot accommodate the condom. If the condom accidentally slips off, the woman will have to carefully pull it out with a finger, taking care not to spill any semen that may cause pregnancy.

Myth: Condoms break or tear during intercourse

Fact: Condoms are made out of thin latex rubber and underwent extensive laboratory tests for strength. Prior to use, the condom should be stored properly, away from heat. Condoms should be used only once. Fact:There is less chance that a condom will break or tear if it is stored and worn properly. A condom may break if there is not enough space left at the tip for the ejaculate.

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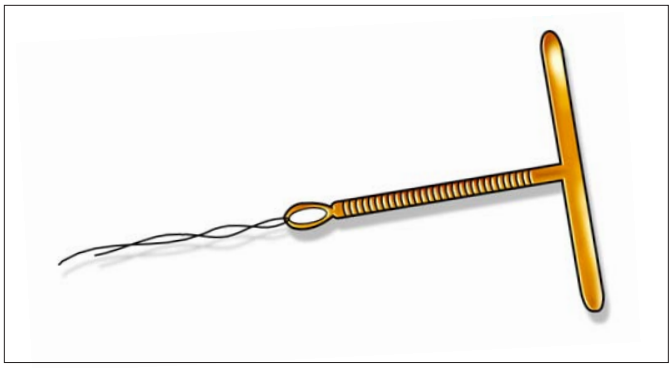


I. IUD (Intra-Uterine Device) – Copper T 380A - a small T-shaped (copper) device that is inserted in the woman's uterus to prevent the union of the sperm and egg cell.

Who should not use?

Women who have the following conditions (contraindications):

Absolute contraindication:

- Suspected pregnancy
- Cancer of the uterus, cervix, ovaries, or the pelvic organs
- Infection/pelvic inflammatory diseases (PID)
- Current sexually transmitted diseases (STDs), e.g., gonorrhea
- Recurrent or chronic PID
- Acquired immune-depression due to drugs or other causes such as AIDS
- Recent septic abortion until infection is completely cleared
- Women at high risk of STDs, e.g., with multiple sexual partners
- Acute cervicitis

Relative contraindications:

- Rheumatic heart or other infections affecting the valves and muscles of the heart
- History of ectopic pregnancy

- Moderate or severe anemia
- Very heavy menstrual flow/severe dysmenorrhea
- For copper-bearing IUD, allergy to copper and metabolic disorders caused by copper
- Nulliparity (not having borne a child) especially with history of PID or ectopic pregnancy.
- Undiagnosed abnormal genital tract bleeding
- Poorly controlled Diabetes Mellitus (until condition is controlled)
- Congenital abnormalities or benign tumors of the uterus (fibroids) which may distort the uterine cavity in a manner incompatible with proper IUD placement
- History of rheumatic fever

A woman who chooses IUD should understand the following:

1. She can expect:
   - Some cramping pain for the first day or two after insertion.
   - Some vaginal discharge for a few weeks after insertion. This is normal.
   - Heavier menstrual periods. Possible bleeding between menstrual periods, especially during the first few months after IUD insertion.
2. Checking the IUD

Sometimes IUD's come out. This can happen especially in the first month or so after insertion or during menstrual period. An IUD can come out without the woman feeling it.

A woman should check that her IUD is in place:

- Once a week during the first month after insertion.
- After noticing any possible symptoms of serious problem.
- After a menstrual period, from time to time. IUD's are more likely to come long with menstrual blood.

To check her IUD, a woman should:

- Wash her hands.
- Sit in a squatting position.
- Insert 1 or 2 fingers into her vagina as far as she can until she feels the string. She should return to the health care provider if she thinks the IUD might be out of place.

Note: She should not pull on the string. She might pull on the IUD out of place.

Disadvantages

- provider is needed to initiate or discontinue using
- may cause minor pain and/or discomfort during insertion and removal procedures
- may increase the incidence of pelvic inflammatory infection and subsequent fertility in women who are at high risk for reproductive tract infection and other sexually transmitted diseases (e.g. women with multiple sex partners)
- may be expelled (woman needs to check for IUD strings monthly after menstruation)
- no protection against STDs/HIV

Possible side effects

- pain and/or cramping during menstruation
- prolonged and heavy menstrual bleeding

Common Myths

Myth: The thread of the IUD traps the penis during intercourse. Men can feel the string and cause pain during intercourse.

Fact: The IUD is inserted into the uterus and the nylon strings attached to it extend to the vaginal canal to allow the woman to check if the device is in place. The strings are soft and cling to the walls of the vagina and are rarely felt during intercourse. The strings are short and cannot trap the penis.

Myth: A woman who has an IUD cannot do heavy work.

Fact: Having an IUD should not stop a woman from carrying out her regular activities. There is no relation between performance of chores of tasks and the use of IUD.

Myth: The IUD travels inside a woman's body to her heart.

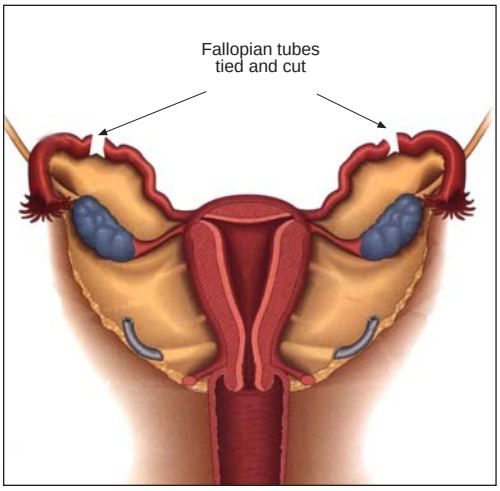
Fact: The IUD is placed inside the uterus and stays there until a trained doctor, nurse or midwife removes it for a particular reason. There is no passage from the uterus to the other organs of the body. If the IUD is accidentally expelled, it comes out to the vagina that is the only passage from the uterus.

Myth: A woman who had an IUD became pregnant. The IUD became imbedded on the baby's forehead.

Fact: The baby is very well protected by amniotic sac inside the uterus. If a woman with an IUD accidentally gets pregnant, the doctor will decide whether to remove the IUD or not. If the doctor decides to leave the IUD in place, the woman should have a regular prenatal check up. The IUD is usually expelled with the placenta or with the baby at birth.

Myth: The IUD rots in the uterus after prolonged use.

Fact: The IUD is made of plastic materials with copper wire that will not rot. The woman will have to report to the clinic regularly for check up. It can remain inside the uterus up to 10 years.



J. Bilateral Tubal Ligation (BTL) – a minor 15-minute surgical procedure done by a trained physician whereby the fallopian tubes are tied and cut to prevent the egg from meeting the sperm.

Advantages

- Highly and immediately effective after the procedure
- Permanent. A one-time procedure which eliminates the effort of buying and using contraceptives – for couples who are sure not to have anymore children
- Has no systemic side effects
- Does not lessen the couple's sexual desire and enjoyment. This may even enhance sexual relationship.
- Convenient, being an outpatient procedure that requires only a minor operation. No resupply needed
- Has beneficial non-contraceptive effects (partial protection from ovarian cancer and Pelvic Inflammatory Disease)

Disadvantages

- Chance of regret if the couple is not absolutely sure not to have children anymore
- Surgical Procedure (occurrence of the usual temporary post operative problems like, swelling, discomfort and pain at the incision site)
- No protection from STDs/HIV
- In a rare case where the operation failed and the woman becomes pregnant, there is high possibility that it would be ectopic

Possible Side Effects

- Some short term pain and discomfort during and right after the procedure
- Complications associated with anesthesia or the procedure itself are rare
- No known long term side effects

Common Myths

Myth: A woman who has been ligated loses all desire for sex/becomes frigid. A woman who has been ligated becomes a sex maniac.

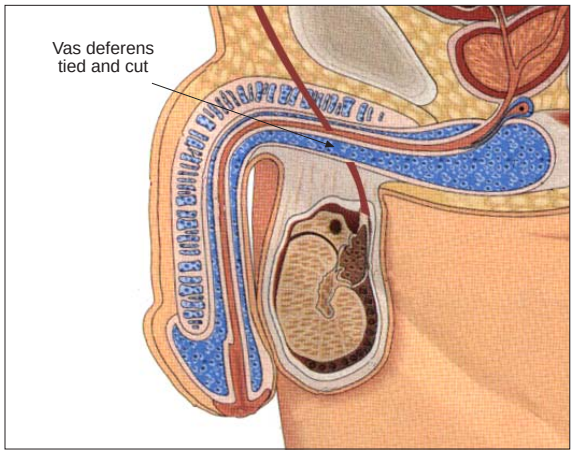
Fact: The operation does not have any physiological effect on a woman other than preventing the egg from being fertilized by the sperm. Her ovaries will still release eggs and produce hormones and she will menstruate monthly. But she will not get pregnant anymore. The egg released during ovulation will disintegrate and be absorbed by the body. The operation will not make a woman lose any of her feminine characteristics.

Myth: A woman who has been ligated becomes sickly and unable to do any work.

Fact: A woman who has been ligated can resume regular activities as soon as she is free from any discomfort after the operation. If the woman has some complaints, it is advisable for her to see the doctor because she may have other illness not related to her ligation.

Myth: Ligation shortens the life of a woman

Fact: There is no medical reason for a ligated woman to have a shorter life span. Although ligation is a surgical procedure, it is being carried out on a healthy person and there is no reason of her to have a shorter life because of the operation.



K. No Scalpel Vasectomy -No-scalpel vasectomy is a 10-15 minute surgical procedure done under local anesthesia where the vas deferens are isolated and fixed using a specially-made extracutaneous ringed forceps, then dissected and lifted from sheath using a dissecting forceps. A portion of each vas deferens is cut and tied.

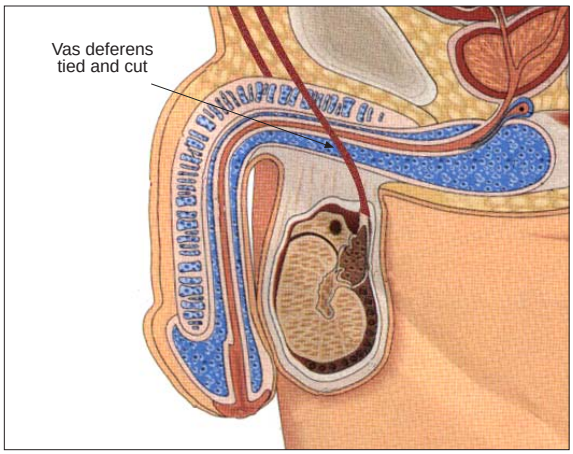
The Procedure:

1. A consent is obtained from the patient.
2. The area is prepared for the procedure.
3. Anesthesia is injected.
4. A ring-clamped is use to elevate the vas deferens by clamping the skin of he scrotum.

5. The skin of the scrotum is punctured using a pair of dissecting forceps and both the tips of the forceps is inserted.
6. The tissues are spread to make the skin opening twice the size of the vas deferens.
7. The wall of the vas deferens is pierced using the blade of the dissecting clamp.
8. The ringed clamped is released and the dissecting clamp is used to lift the vas deferens.
9. The vas is grasped using the ringed clamp.
10. The sheath is punctured and strip with one tip of the dissecting forceps.
11. Both tips of the dissecting forceps is inserted into the punctured sheath.
12. The dissecting forceps is opened to strip the sheath.
13. A segment of the vas (about 1 mm.) is removed and and the cut ends are ligated.
14. Same procedure is repeated on the other vas.

No Scalpel Vasectomy are for men who:

- Have completed families and have decided to share the responsibility in family planning.
- Have wives' with contraindication on the use of temporary family planning method.
- Have shown poor compliance with temporary Family Planning method.



Advantages

- Highly effective and reliable
- Permanent
- Has no systemic side effects
- Does not lessen the man's sexual desire and enjoyment. It may even enhance sexual relationship
- Less surgical risk/expense than female sterilization
- Nothing to remember except to use condoms or another effective method for at least the first 20 ejaculations or the first 3 months, whichever comes first
- Increased sexual enjoyment because no need to worry about pregnancy.
- No resupply needed

Disadvantages

- Chance of regret if the couple is not absolutely sure not to have children anymore
- Risks and side effects of minor surgery
- Delayed effectiveness (needs several ejaculations before he is cleared from sperms)
- No protection from STDs/HIV

Possible Side Effects

- Some short term pain and discomfort during and right after the procedureÊ
- Requires minor surgery by a specially trained provider
- Not immediately effective. At least the first 20 ejaculations after vasectomy may contain sperm.

Common Myths

Myth: Vasectomy is castration.

Fact: In vasectomy, the vas deferens are cut and tied so that sperm cannot mix with the semen. The vasectomized man will continue producing male hormones. In castration, the testicles (the organ where male hormones are produced) are totally removed. A castrated male can no longer engage in sex and is less likely to have masculine characteristics.

Myth: Sperm that is not ejaculated during intercourse will collect in the scrotum and cause the scrotum to burst.

Fact: Sperm that is not ejaculated is absorbed by the body.

Myth: Vasectomy will make a man lose his sexual ability.

Fact: After vasectomy, a man will look and feel the same as before. He can have sex the same as before. He may find that sex is better since he is free from worry about making his partner pregnant. He can work as hard as before. His erections and ejaculations of semen will be the same. His beard will still grow. His voce will not change.

Myth: Vasectomy will stop working after a time.

Fact: Vasectomy is permanent. In rare cases the tubes grow back together but this is unlikely.

Myth: Vasectomy is not reversible.

Fact: Surgery to reverse vasectomy is possible. However, it does not always lead to pregnancy. The procedure is difficult, expensive and hard to find. Vasectomy should be considered permanent. People who may want more children should choose another method.

Myth: Ligation is better than vasectomy.

Fact: Each couple must decide for themselves which method is best for them. Both are very effective, safe and permanent methods for couples who know that they will not want more children. Vasectomy is simpler and safer to perform. It is less expensive and slightly more effective.

Who provides Family Planning and Where?

Method	Who can provide?	Where
Lactational Amenorrhea Method (LAM)	The breastfeeding woman herself provides the method. Knowledgeable and supportive health care providers can help her use it most effectively.	Trained Health service providers in Rural Health Centers (RHU), Barangay Health Centers (BHS), fertility clinics.
Basal Body Temperature (BBT) Method	Anyone specifically trained to teach fertility awareness.	Trained Health service providers in Rural Health Centers (RHU), Barangay Health Centers (BHS), fertility clinics. Client's or provider's home
Ovulation Method (OM) or Cervical Mucus Method		
Sympto-Thermal Method		
Standard Days Method (SDM)		
Pill	Nurses, midwives, physicians, Barangay health workers, Barangay service point officer.	Rural Health Centers (RHU), Barangay Health Centers (BHS), or in the client's or service provider's home Pharmacies
DMPA (Depo-Medroxy Progesterone Acetate) or Injectables	Anyone trained to give injection and to handle needle and syringes properly.	Rural Health Centers (RHU), Barangay Health Centers (BHS), Pharmacies – supply only
Condom	Anyone.trained to give proper instruction on how to properly store, use and dispose the condom	Rural Health Centers (RHU), Barangay Health Centers (BHS), or in the client's or service provider's home Pharmacies
IUD (Intra-Uterine Device)	Anyone with training in medical procedures and specific training in IUD screening, insertion and removal, including physicians, nurses and midwives.	Trained Health service providers in Rural Health Centers (RHU), Barangay Health Centers (BHS), fertility clinics. Wherever appropriate infection-prevention procedure can be followed, including clinics, hospitals, and physicians' offices.
Bilateral Tubal Ligation (BTL)	With specific training, general physicians, specialized physicians such as obstetricians and gynecologists.	In facilities where surgery can be done.
No Scalpel Vasectomy	With specific training, physicians, medical officers, (nurses and midwives as assistants only)	Almost any health facility, including physicians' offices, clinics,and temporary clinics.